ADVANCE HEALTH CARE DIRECTIVE

Part 1: To be completed by Health Care Staff

Inmate Name: _____ Date: _____

CDC Number: _____ Institution: _____

ASSISTANCE SCREENING

☐ Participant in the Mental Health Services Delivery System (MHSDS) at the following level of care:

☐ CCCMS ☐ EOP ☐ MHCB ☐ DMH CDC 128-C dated _____

☐ Identified Learning Disability: CDC 128-B dated _____

☐ Participant in the Developmental Disability Program in the following category:

☐ DD1 ☐ D1A ☐ DD2 ☐ DD3 CDC 128-C-2 dated _____

☐ Identified with a Disability that significantly impacts communication:

☐ DPV ☐ DPS ☐ DPH CDC 1845 dated _____

☐ Reading Score Below 4.0 (Reading Score _____) CDC 128-B dated _____

☐ Primary language is not English. Inmate speaks _____

☐ NO EFFECTIVE COMMUNICATION ASSISTANCE NEED (identified in the Central File)

_____ _____ _____

Staff Printed Name Staff Signature Date

STAFF ISSUANCE

☐ This case was forwarded to the notary as no assistance with effective communication was identified.

☐ This case was forwarded to the CMO or licensed health care professional to meet with inmate to ensure he/she understands the purpose of this Advance Directive and the decision being made regarding their future health care.

☐ This case was forwarded to the Chief Psychiatrist or designated mental health care professional to meet with the inmate to determine whether or not the inmate has the mental capacity to make a decision regarding future health care.

_____ _____ _____

Staff Printed Name Staff Signature Date

STAFF OBSERVATION

☐ I have met with the inmate and communicated the purpose of this Advance Directive and discussed the decisions he/she is making regarding their future health care and he/she:

☐ Appears to understand without assistance ☐ Does not appear to understand (assistance required)

☐ Assistance provided (i.e. foreign language interpreter, sign language interpreter, read/spoke slowly, assistive device, etc)

After providing assistance, inmate/parolee:

☐ Explained the conditions in his/her own words ☐ Does not appear to understand

_____ _____ _____

Staff Printed Name Staff Signature Date

Distribution: Original-UHR, Copy Inmate

ADVANCE HEALTH CARE DIRECTIVE INSTRUCTIONS

PART 2: To be completed by Inmate

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(Name of individual you choose as agent)

_____

(Address) (City) (State) (ZIP Code)

_____

(Home Phone) (Work or Secondary Phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

(Name of individual you choose as first alternate agent)

_____

(Address) (City) (State) (ZIP Code)

_____

(Home Phone) (Work or Secondary Phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a Health care decision for me, I designate as my second alternate agent:

_____

(Name of individual you choose as second alternate agent)

_____

(Address) (City) (State) (ZIP Code)

_____

(Home Phone) (Work or Secondary Phone)

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or Withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

(Add additional sheets if needed)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ☐, my agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown; my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interests. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state on this form:

_____

_____

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR: If a conservator needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice(s) I have marked below:

☐ **(a) Choice Not To Prolong Life**
I **do not** want my life to be prolonged if:

(1) I have an incurable and irreversible condition that will result in my death within a relatively short time,

(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness,

(3) The likely risks and burdens of treatment would outweigh the expected benefits, **OR**

☐ **(b) Choice To Prolong Life:**
I **do** want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

DONATION OF ORGANS AT DEATH (OPTIONAL)

Upon my death (mark applicable box):

☐ **(a)** I give any needed organs, tissues, or parts, OR

☐ **(b)** I give the following organs, tissues, or parts only.

_____

My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: Sign and date the form here:

_____
(Print your name) (Address)

_____
(City) (State) (Zip Code)

_____
(Signature) (Date)

NOTARY SECTION
Part 3: To be filled out by Notary Public

State of California }
}ss.
County of _____ }

On _____, before me _____, Notary Public,
(date) (Notary name)

personally appeared _____, personally known to me
(Name)

(or provided to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

Signature_____ Official Notary Seal